public record of the arguments and assumptions underlying the Government’s handling of social services expenditure. Nowhere else are ministers and their senior civil servants questioned so closely and so publicly about their activities or their replies evaluated so critically. Secondly, the report shows the urgent need, in evaluating health and social service policies, of thinking simultaneously about costs and benefits. Without a coherent set of objectives and the means to measure the degree of their attainment questions about the effectiveness and efficiency of services cannot be answered rigorously. As the Committee put it, “Our underlying question is: What is the NHS trying to do, and what is the relationship between expenditure plans and the Government’s policy objectives?” And while the committee was not particularly impressed with the quality of the replies it received at the first time of asking it clearly intends to pursue the matter. As it remarked, rather tartly, “We look forward to obtaining a more enlightening response from the department when next we inquire.”


Millions of mild hypertensives

The Veterans Administration Co-operative Study Group trial of the treatment of hypertension, reported in 1970,1 showed that there was still insufficient evidence to justify starting treatment for the many millions of mild hypertensives in the general population. In that trial statistically significant benefits of treatment were shown only in cases with diastolic pressures between 105 and 114 mm Hg; there was only some suggestion of benefits in the milder group. All concerned sat back to wait for the results of further, more detailed and comprehensive studies. One small trial of treatment of mild hypertensives reported from the United States in 1978 showed very little benefit,2 as did a small hospital-based study from England.3 This year, however, the results of two large-scale studies have been published, one from America and one from Australia. Their design and findings seem likely to provoke sustained discussion.

The American Hypertension Detection and Follow-up Programme is perhaps the more difficult to interpret,4 5 since it was more of a trial of systematic versus unsystematic medical care of blood pressure in the population than an exercise in clinical pharmacology. Half the patients with hypertension were referred to special clinics and received “stepped care” of their blood pressure along with advice on cigarette smoking, obesity, hypercholesterolaemia, and salt; the control patients were simply referred back to their normal medical services, and many received excellent treatment. The “stepped-care” group of mild hypertensives fared better, with fewer deaths, though no benefits were found in white women. Only data on mortality are available as yet, and a different picture may appear in the pattern of non-fatal complications. Whatever the outcome, this study seems unlikely to influence the treatment of mild hypertensives in Europe; its findings are relevant primarily to the American system of medicine.

The Australian National Blood Pressure Study6 7 reported its preliminary results in 1979, and a more detailed description of its trial and its conclusions are now available.7 This was a more conventional clinical trial in which patients were randomly allocated to active or placebo treatment groups but otherwise received identical medical care. Statistically significant benefits from treatment were found only in patients whose diastolic pressures before treatment were 100 mm Hg or more. Furthermore, this treatment prevented both heart attacks and strokes. Until recently antihypertensive treatment had been thought not to prevent coronary heart disease,8 9 but this seems no longer true, as both the American and the Australian trials—and a recent study from Sweden10—have shown that heart attacks were prevented in the treated patients. This may be because in milder hypertensives arterial damage is less than in severe hypertensives so that early treatment may prevent further deterioration. The previous failures to prevent coronary disease may simply have been because treatment was started too late—when hypertensive vascular damage was too far advanced. This evidence suggests that the one million middle-aged citizens of Britain with mild hypertension do require drug treatment, since this will prevent both heart attacks and strokes.

The mild hypertension story is, however, not over. There is still uncertainty about the possible benefits of drug treatment in the remaining three million middle-aged Britons with diastolic pressures of 90 to 99 mm Hg. There is now only one more major trial of the treatment of mild hypertension to come; the British Medical Research Council trial11 has the sole responsibility for answering this crucial question. Just as important is a second question: Are the benefits of treatment likely to be offset by an increase in the anxiety, distress, and side effects as well as cost of drug taking? Medicine which is good for the patient may not always be good for the person.

Whatever the results of the Medical Research Council trial, the logistic problems for doctors of dealing with millions of mild hypertensives have to be faced. At least half of the hypertensive citizens of Britain are undetected, and those who are detected are mostly receiving inadequate treatment.12 Hypertension is the most common condition requiring treatment, and positive steps have to be taken by the entire medical and nursing professions to improve standards. This is primary medical care at its most important: the main burden of responsibility for mild hypertension rests firmly in general practice. While some family doctors have grasped the nettle and started systematic case detection and follow-up programmes,13 11 most have not. Hospital-based doctors and community physicians have the responsibility to do all they can to help, but the prime responsibility is in general practice. This is a very exciting time for general practitioners and none can afford not to start the organisation of case detection and treatment of their many patients with diastolic pressures of 100 mm Hg or more.

1 Veterans Administration Cooperative Study Group on Antihypertensive Agents. Effects of treatment on morbidity in hypertension: II. Results in patients with diastolic blood pressure averaging 90 through 114 mm Hg. JAMA 1970;213:1143-52.
4 Hypertension Detection and Follow-up Program Cooperative Group. Five-year findings of the hypertension detection and follow-up program. Reduction in mortality of persons with high blood pressure, including mild hypertension. JAMA 1979; 242:2562-71.
Uraemic pruritus

Pruritus is not a feature of acute renal failure but is common in severe chronic renal failure, the reported incidence being as high as 86%. Many factors have been incriminated. Patients commonly have a dry skin (xerosis), and this may contribute to the pruritus. The xerosis may be related to the atrophy of the sebaceous glands and the eccrine sweat glands that occur in uraemia. The disturbances of calcium and phosphorus metabolism in chronic renal failure have also been implicated, while other possible factors include the proliferation of mast cells in the skin of some patients with uraemia, and high serum concentrations of magnesium, and an association with uraemic neuropathy. With so many possibilities the only certainty is that the mechanism of uraemic pruritus remains unknown.

Regular and intensive haemodialysis is said to cure or improve pruritus in many patients, but some reports have put the proportion relieved of their symptoms as low as 14%. Sometimes the pruritus may worsen or appear for the first time after starting maintenance haemodialysis. In some (but not all) patients with severe secondary hyperparathyroidism subtotal parathyroidectomy may dramatically improve or cure intractable pruritus. Not all patients with severe secondary hyperparathyroidism have pruritus, however, and many who have intractable pruritus do not have severe secondary hyperparathyroidism. Uraemic pruritus may be helped by simple measures such as skin emollients, systemic anti-histamine preparations, and minor tranquillisers. Very low protein diets may help, and so may saunas. Recently a whole variety of treatments have been tried in patients being treated with maintenance haemodialysis with intractable pruritus; but the best answer is renal transplantation with a good functioning graft.

Among the empirical treatments that have been commended is regular intravenous heparin for several weeks; good results were claimed but these were uncontrolled observations. A double-blind trial comparing intravenous lignocaine with placebo saline during haemodialysis showed an improvement in the patients given the drug. Oral cholestyramine gave good results in one controlled trial but not in another— and cholestyramine carries a possible risk of inducing or aggravating a metabolic acidosis in uraemic patients. Ultraviolet phototherapy has also been tried and was effective in a controlled trial.

Pruritus is a notoriously difficult symptom to assess, and in all these trials with lignocaine, cholestyramine, and ultraviolet phototherapy the numbers were small; but these treatments may be worth trying in patients with intractable itching. A final note of caution: patients with severe uraemia are not immune from other causes of pruritus, such as scabies.

Sterilisation of mentally retarded minors

Severe mental handicap in a child is always a heavy burden for parents, but the circumstances are especially distressing when a girl is approaching the reproductive years. The risk of pregnancy is greater now than in the past, when more of these girls were cared for in single-sex institutions. There is an understandable concern to protect the youngster from pregnancy, and the parents may well seek medical advice and help. Some form of contraception may be offered, but at this age and in these circumstances none is really satisfactory. The two obvious choices—an intrauterine device and an injectable